FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

July 31, 2014

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U.S. Department of Health and Human Services
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RE: May 2, 2014 FAQ about Affordable Care Act Implementation (Part XIX); Families USA Recommendations Regarding Federal Standards for Reference Pricing Structures

To Whom It May Concern,

Families USA appreciates the opportunity to comment on the May 2, 2014 FAQs About Affordable Care Act Implementation, regarding the Departments' of Labor, Health and Human Services and the Treasury (the Departments) proposed policy on reference pricing structures and group health plan compliance with out-of-pocket spending limits under the Affordable Care Act (ACA). Families USA is a national non-profit, non-partisan organization dedicated to the achievement of high quality, affordable health coverage and care for all.

Families USA recognizes that reference pricing can be an effective tool to address unwarranted price variation across providers in a region. However, we have significant concerns with the Departments' proposed interim policy to allow group health plans to treat only providers that fall within a reference price as in-network for the purpose of implementing out-of-pocket spending limitations under the ACA.

We share the Departments' concerns that reference pricing could also be used in abusive ways to undercut core financial protections established in the ACA, shift costs to consumers, and restrict consumers' access to high quality, affordable care. Without federal standards in place, there is no assurance that plans will set fair reference prices that are inclusive of an adequate network of providers, or that plans will apply reference prices to appropriate services or provide consumers with adequate education and support to help them obtain care from a provider that is within a reference price.

We appreciate the Departments' request for recommendations regarding federal standards for reference pricing structures in group health plans and offer recommendations regarding adequate standards in our comments.

However, until federal standards exist to ensure that this pricing structure is not used in abusive ways, we strongly recommend that consumers' out-of-pocket spending for costs that exceed a reference price count toward their in-network out-of-pocket spending limit, as long as care is delivered from a provider that is generally in-network but exceeds the reference price.

While not addressed within the FAQ, we also strongly recommend that, prior to federal standards being established, out-of-pocket costs for care that exceed a reference price count toward a consumer's in-network deductible if such care was obtained from an otherwise in-network provider.

In addition, we strongly believe that reference pricing should be limited to group health plans and not be permitted in individual health plans, either inside or outside of a state's marketplace. While many group health plans implementing reference pricing have been able to provide robust and targeted support to enrollees in connection with their employer, in the individual market we have significant concerns that consumers will not have the help they need to understand their plan's reference pricing program and to find care within a reference price.

Many consumers who have enrolled in health plans on their own through the marketplace are new to insurance and may still be struggling to understand the basics of how to use their insurance. This is exacerbated by the fact that many consumers have struggled to obtain adequate, easily understandable information about their new plan's benefits and provider networks. **In the individual market, plans should prioritize helping consumers understand and use their new health insurance, and not add complexity to benefits in manner that could likely shift unaffordable costs to consumers.**

Recommendations Regarding Federal Standards for Reference Pricing in Group Health Plans:

The end goal of reference pricing should be to encourage consumers to opt for care from high-value providers and, in doing so, to exert meaningful pressure on overly expensive providers to lower their prices for care. Reference pricing must be structured in consumer-friendly ways in order to achieve these goals: Consumers must understand their plan's reference pricing and must be able to easily obtain care within the reference price, in order to generate real pressure on providers to lower their prices.

We offer the following recommendations for standards that should be required of plans that use reference pricing to ensure reference pricing is structured to effectively combat price variation and is not abused to limit access to care. We strongly recommend that health plans be required to

comply with such standards before being allowed to treat only providers within a reference price as in-network for the purpose of adherence to cost-sharing protections under the ACA.

Ensuring Plans Have Adequate Price Transparency

In order to implement reference pricing, a health plan or self-insured employer must have access to accurate information about the negotiated prices in-network providers receive for care and must be able to share this information with their enrollees. Health plans or employers must have this information in order develop a well-built reference pricing program. They need it both to identify services where there is immense price variation and to inform what the reference price for that service should be. For consumers, this information is critical in order for them to compare providers based on price.

Health plans typically have access to this level of price information. However, this does not mean that employers or, especially, enrollees will have access to this information. In fact, in some states, health plans and providers are allowed to have contractual agreements that prohibit the plan from sharing this level of information with enrollees and even self-insured employers that contract with the health plan to administer benefits. Under such limitations, it is impossible to implement reference pricing in a consumer-friendly and effective way.

Federal standards must specify that health plans or employers can only implement reference pricing if they have access to the negotiated prices providers receive for services and are able to share that information with enrollees. As discussed in later recommendations regarding consumer support and education on page 7, health plans implementing reference pricing must provide easy-to-understand price information to consumers through multiple formats.

Limiting Reference Pricing to Appropriate Services

Reference pricing is not an appropriate tool for all types of care. For example, it is never appropriate to apply reference pricing to services delivered during a course of emergency or urgent care, regardless of the procedure. In these situations, consumers do not have the time or ability to compare providers based on price and quality due to the urgency of their medical needs and should not face financial repercussions for going to more expensive providers.

Reference pricing is also not appropriate for highly specialized care where people may struggle to find a provider that fits their unique needs and where people may have serious conditions that are being treated. This includes, but is not limited to, oncology services and mental health services.

Reference pricing is only appropriate for limited scheduled, standard health care procedures for which consumers truly have the time and ability to compare providers. These include pre-

scheduled lab and imaging services, or scheduled standard surgeries, like hip or knee replacement surgery.

Health plans should limit the number of services for which they set reference prices to ensure that consumers fully understand the program. Setting reference prices for too many services is likely to make it more difficult for consumers to fully understand their benefits and which services have a reference price. We have significant concerns that this could result in consumers being unaware that needed care is subject to a reference price and, consequently, their facing unexpected out-of-pocket health care expenses due to their unknowingly opting for care above a reference price.

We also believe it is critical that health plans consider how best to preserve coordination of care when implementing reference pricing. For example, if a consumer generally receives all of his or her care within one medical or hospital system, requiring that consumer to go outside of that system for one procedure or imaging test could disrupt care coordination. This could ultimately lead to duplication of services or other costly consequences that can result when care is uncoordinated, thereby nullifying the cost-saving benefits of reference pricing. Plans may want to consider reference pricing exceptions (described on page 6) for situations in which applying reference pricing requirements to services that are otherwise appropriate for reference pricing would harmfully disrupt a consumer's care coordination.

Federal standards should specify that health plans can never apply reference pricing to procedures delivered during a course of urgent or emergency care, including care provided once an emergency patient is admitted to the hospital. In addition, federal standards should prohibit plans from applying reference pricing to oncology services, mental health services and other types of highly specialized care where people may struggle to find a provider that fits their unique needs and where people may have serious conditions that are being treated.

Federal standards should specify that reference pricing must be limited to select scheduled, standard procedures; plans must limit the number of procedures that are subject to a reference price; and plans must consider continuity of care when selecting these procedures.

Prohibiting Reference Pricing When Provider Networks Are Inadequate

If a plan is already struggling to maintain an adequate network of providers within a particular geographic area, specialty, or otherwise, it should not be permitted to implement reference pricing in that geographic area, or for any services primarily delivered by that specialty. This would further restrict an already insufficient network of providers. This is particularly important given the historical problems of plans not maintaining adequate networks of providers across certain regions or specialties, including primary care providers, oncologists, and mental health providers, as recognized in HHS' 2015 Final Letter to Issuers in Federally Facilitated

Marketplaces.[1] Plans for which regulators at the federal or state level have received network adequacy complaints from consumers must be barred from implementing reference pricing requirements.

To ensure that reference pricing is not exacerbating existing provider access problems experienced by consumers, federal standards should require plans to grant exceptions from reference pricing requirements for any consumer who cannot obtain care from a provider who meets reference price requirements under the following network adequacy standards:

- **For services delivered in primary care settings, people should be granted exceptions from reference pricing requirements if they must travel more than 30 minutes to receive services. These are the network adequacy requirements applied in many states, including California, Delaware, Minnesota, Texas, New Jersey, and Vermont, to some or all plans regulated by the states. The 30 minutes should apply to travel time by car or public transit, whichever mode of transportation upon which the patient relies. For specialist services, the travel time standard should be 60 minutes. This is the standard used for some or all plans in states such as Minnesota, New Jersey, and Vermont.[2]**

- **People should also be granted exceptions from reference pricing requirements if they have to wait unduly long for an appointment in order to receive a service from a provider who meets reference pricing requirements. The following standards from California should serve as a model for how to qualify for an exception for this reason[3]:**

    - *Enrollees must be offered appointments in the following time-frames or may receive an exception:*

        1. *Within ten business days of a request for non-urgent primary care appointments,*

        2. *Within fifteen business days of a request for an appointment with a specialist,*

        3. *Within fifteen business days of a request for a non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition.*

[1] Center for Consumer Information and Insurance Oversight, *2015 Letter to Issuers in the Federally-facilitated Marketplaces* (Washington: Department of Health and Human Services, March 14, 2014).
[2] Sally McCarty and Max Farris, *ACA Implications for State Network Adequacy Standards* (Washington: Georgetown Health Policy Institute, August 2013), available online at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407486; N.J.A.C. 11:24–6.2; Vt. Admin. Code 4-5-3:10.500
[3] http://www.dmhc.ca.gov/HealthCareLawsRights/HealthCareRights/TimelyAccess.aspx#.U7ClSqjc2zQ

Federal standards should also require plans to grant an exception from reference pricing requirements if consumers cannot find a provider within a reference price that is language-accessible to them. The Departments should also consider how to ensure that reference pricing does not create undue barriers to care for individuals who rely on providers who are available during non-standard business hours due to their work schedules. Considering these issues is critical to ensuring that lower-wage workers and communities of color do not experience undue financial burdens or disruptions in care if their employers introduce reference pricing programs.

Ensuring Plans Set Fair Reference Prices

Plans must set fair reference prices that ensure that they have an adequate network of high quality providers within this price threshold. This is critical in order to ensure that plans do not use reference pricing to either shift costs to consumers or hinder access to care. In addition, it is critical that plans maintain the same reference price for a given service for the entirety of a plan year. We have serious concerns that changes in reference prices mid-year could lead to significant consumer confusion and could increase the likelihood that consumers inadvertently obtain care from a provider that costs more than the plan's revised reference price.

Specifically, federal standards should specify that plans must set reference prices high enough so that there are a sufficient number of providers within the reference price to ensure that enrollees can obtain care within the reference price *and* within the travel time and appointment wait-time standards specified in the previous section's recommendations. Setting reference prices too low would result in there being an insufficient number of providers within the reference price to serve the medical needs of the enrollee population in a reasonable and timely manner. Federal standards should also specify that plans must maintain the same reference price for a given service for the full duration of a plan year.

Exceptions Process to Ensure Access to High-Quality and Patient-Centered Care

In addition to exceptions due to plans not meeting the above mentioned network adequacy standards, plans must have an easily accessible exceptions processes for other situations in which it is difficult for consumers to obtain patient-centered, high quality care within the reference price.

This should include, but not be limited to, exceptions so that consumers do not have to cover additional costs for care that exceed a reference price, in the situation that they need more complex care, such as more expensive services, or care from a more specialized, expensive provider, due to unexpected complications or co-morbidities.

Federal standards should require plans to grant automatic exceptions from reference pricing requirements if a consumer unexpectedly needs additional services or more complex care in the midst of his or her treatment due to complications. Plans should also be required to grant exceptions from reference pricing requirements in the situation that a

consumer needs to receive care from a more specialized, expensive provider because co-morbidities complicate the delivery of care.

Consumers requesting any exception should have the right to an external appeal.

Ensuring Adequate Consumer Education and Support

Plans must have robust consumer outreach, education, and support to ensure that enrollees understand their plan's reference pricing policy and have adequate help obtaining care within a reference price. For many consumers, common components of health plan benefits, such as in-network vs. out-of-network providers, may already be confusing. Reference pricing adds additional complexity to these concepts, as some providers may generally be treated as in-network but still not fall within the reference price for a particular service.

Ensuring that consumers have the help they need to obtain care within the reference price is a critical consumer protection. It is equally critical in order for reference pricing to successfully pressure providers to lower prices. The more consumers actually opt for care from providers within the reference price, the greater the incentive for more expensive providers to lower their prices.

Federal guidance should specify that, at a minimum, plans must supply consumers with the following:

1. An annual notice that describes how the plan's reference pricing program works, how to obtain help accessing care within a reference price (including a telephone number, as specified below), how to obtain an exception from the plan's reference pricing requirements, and links to the online list of providers that fall within the reference price and the online provider comparison tool, which we recommend below. The Departments should develop proposed model language for such a notice that is open for public comment.

2. An accurate, up-to-date list of providers that fall within the reference price for a given service, including up-to-date provider contact information. This list should include indications of which providers deliver exceptionally high-quality care, based on their performance on quality measures.

   This list must be guaranteed, meaning that if a consumer goes to a provider on this list, they cannot be responsible for covering excess costs. If there are changes to which providers fall within the reference price and are in-network mid-year, the plan must send a revised list to consumers. Plans must mail the original provider list (and any revised lists) to consumers and must also maintain an up-to-date list that is available online.

3. An assistance phone line where consumers can receive help finding a provider within the reference price and can obtain information regarding the price and quality of different

providers. The telephone number for this assistance line should be included in the annual notice.

4. An online tool that allows enrollees to search for nearby providers that fall within a reference price and compare providers based on price and quality. At a minimum this online tool should include easy to understand price and quality information alongside up to date contact information for providers, and a search function that allows consumers to search for providers by zip code and other preferences.

5. When an enrollee is pre-authorized for a service subject to a reference price, a health plan must contact that individual by phone to explain the reference pricing program and offer to help him or her find care within the reference price.

Federal guidance should also specify that plans are expected to develop additional targeted outreach strategies to educate those enrollees that are most likely to need services that are subject to a reference price. For example, CalPERS' reference pricing program for hip and knee replacement surgeries sent targeted mailings about the program to all enrollees who had visit an orthopedist for hip or knee problems within the past year.[4] Plans should also consider other outreach strategies, such as educational sessions for enrollees at their place of employment.

Additionally, plans should be expected to notify in-network providers affected by reference pricing about the program and which providers fall within the reference price. This notification should be sent to both providers that deliver care subject to a reference price and providers that may refer consumers for care subject to a reference price.

Even with these standards, we still have concerns that consumers who are already struggling with health literacy may be adversely affected by a reference pricing program. Federal guidance should also specify that enrollees have the right to be granted an exception from any reference pricing requirements if they are unable to understand their plan's reference pricing structure due to health illiteracy. If they have been subject to reference pricing requirements that they were unable to understand or were not adequately informed about, they have a right to submit an appeal. As a remedy, the plan or reviewer could determine that the consumer is not responsible for covering any excess costs that exceed the reference price.

Requiring Plan Evaluations

A health plan implementing reference pricing should at least annually evaluate whether the program is effective at encouraging consumers to seek care from providers that are within the

[4] Amanda E. Lechner, Rebecca Gourevitch, and Paul B. Ginsburg, *The Potential of Reference Pricing to Generate Health Care Savings: Lessons from a California Pioneer* (Washington: Center for Studying Health System Change, December 2013), available online at http://www.hschange.org/CONTENT/13971/.

reference price and whether the program drives more expensive providers to lower their prices for care.

Federal guidance should require health plans to annually assess:

- Whether additional providers lowered their prices for care subject to a reference price.
- The portion of consumers that still obtained care from providers above a reference price. If a high proportion of consumers continue to seek care from providers that fall above a reference price, it could be an indication that the reference price is too low or that the plan has inadequate education and outreach.
- How the program affects consumers' access to care. For example, a plan should assess whether there is a decline in the number of consumers who obtain a procedure once a reference price is set for it. This could indicate that consumers are struggling to obtain care within the reference price and instead are foregoing necessary care.
- Consumers' experience with the program. This should include survey queries about whether consumers found it easy or difficult to find a provider within a reference price, whether they understand the program and, for consumers who sought care from a provider that charged more than a reference price, why they made that decision. It should also include an examination of complaint and grievance data.

Federal Monitoring and Enforcement Plan

Future federal guidance should also outline a clear federal monitoring and enforcement plan to ensure that health plans are complying with federal standards and are not using reference pricing in abusive manners. We offer the following recommendations on potential methods the Departments could adopt to monitor compliance:

- The Departments should delegate to a single Department the responsibility to collect and respond to consumer concerns regarding specific reference pricing programs. This Department should have a method for consumers to submit concerns both online and by phone. Health plans should be required to include this Department's contact information in its annual notice regarding its reference pricing program.
- The Departments should conduct audits of plans with reference pricing on a regular basis. While some audits may be random, the Departments should also use the above mentioned consumer-submitted concerns to trigger audits of suspicious programs. The Departments should use the results of these audits to publish additional compliance guidance that addresses common reference pricing structures that have been found to violate federal standards.
- The Departments should require states to also monitor concerns regarding reference pricing. With states, the Departments should examine complaint, grievance, and appeals data regarding reference pricing. If complaints indicate that consumers do not understand

reference pricing in a given plan or that they are not able to obtain care within the reference price, plans should not be allowed to continue a reference pricing program until the plan corrects the problem.

We appreciate the opportunity to provide comments regarding this issue. **We believe it is critical that group health plans comply with these recommended federal standards. Until such standards are in place consumers' out-of-pocket spending for costs that exceed a reference price should count toward their in-network out-of-pocket spending limit and deductible, as long as care is delivered from a provider that is generally in-network but exceeds the reference price**. If you have any further questions regarding our recommendations, please contact Lydia Mitts at lmitts@familiesusa.org or (202)628-3030.

Sincerely,

Lydia Mitts
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Families USA